

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-009476  
STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 317

Primary Registration District No. 500

Registrar's No. 290

FILED MAR 7 1962

VS 300  
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY Koch, Missouri		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 136 days	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Robt. Koch Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last William H. White		4. DATE OF DEATH Month Day Year Jan. 22 1962	
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4-28-97
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber-Self Employed		10b. KIND OF BUSINESS OR INDUSTRY	
11a. FATHER'S NAME William J. White		11b. MOTHER'S MAIDEN NAME Ida D. Schrage	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no None		17. INFORMANT Address 3 Koch Hospital record, Koch, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) bronchopneumonia DUE TO (b) cerebral thrombosis 332x DUE TO (c) generalized arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) left C.V.A due to hypertension; B.P.H.		INTERVAL BETWEEN ONSET AND DEATH 3 days ?? years?	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 9-8-61 to 1-22-62 and last saw her alive on 1-22-62 Death occurred at 6:50 A m on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) Robt. Koch Hosp. Koch, Mo. 1-22-62	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE Jan. 25, 1962	
23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
24. FUNERAL DIRECTOR ADDRESS Kriegshauser 4228 S. Kingshighway Blvd.		25. DATE RECD. BY LOCAL REG. 1-23-62	
26. REGISTRAR'S SIGNATURE John C. Murphy M.D.			

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Ernest W. Spillars

Licensed Embalmer No. 4080

P. O. Address \_\_\_\_\_

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.